



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

CENTER FOR PAIN RELIEF  
9080 HARRY HINES STE 110  
DALLAS TX 75235

#### **Respondent Name**

Federal Insurance Co

#### **Carrier's Austin Representative Box**

Box Number 17

#### **MFDR Tracking Number**

M4-12-0825-01

#### **MFDR Date Received**

November 4, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "INSURANCE CARRIER DENIED PAYMENT"

**Amount in Dispute:** \$1,717.90

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "With the reimbursement issued under the request for reconsideration, the Carrier contends the Provider is not entitled to additional reimbursement."

**Response Submitted by:** Travelers

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4 and 18, 2010	Professional Services	\$1,717.90	\$66.38

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE.
  - W1 – WORK COMP STATE FEE SCHEDULE ADJUSTMENT.
  - 59 – CHARGES ARE ADJUSTED BASED ON MULTIPLE SURGERY RULES. MULTIPLE SURGICAL PROCEDURES BILLED ON THE SAME DAY WILL BE REIMBURSED AT 100% FOR THE MAJOR PROCEDURE AND 50% FOR EACH SUBSEQUENT PROCEDURE SAME DAY WILL BE REIMBURSED AT 100% FOR THE MAJOR PROCEDURE AND 50% FOR EACH SUBSEQUENT PROCEDURE.

- 18 – DUPLICATE CLAIM/SERVICE.
- 17 – PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFF/INCOMPL. REVIEW OF SUBMITTED DOCUMENTATION DOES NOT SUBSTANTIATE BILLED SERVICE.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION. THROUGH A REVIEW OF ORIGINAL PYMT AND ADD'L INFORMATION RECEIVED, IT HAS BEEN DETERMINED ORIGINAL INVOICE WAS PROCESSED INCORRECTLY.

### **Issues**

1. Was the disputed service supported?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. The disputed service was denied as 17 – PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFF/INCOMPL. REVIEW OF SUBMITTED DOCUMENTATION DOES NOT SUBSTANTIATE BILLED SERVICE. Per 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part , “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ...and other payment policies in effect on the date a service is provided. The medical bill included CPT code 62311 The American Medical Association (AMA) CPT code description for 62311 as “Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contract for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal). Per Medicare CCI guidelines, Procedure Code 62311 has a CCI conflict with Procedure Code 62319. No additional payment can be recommended.
2. 28 Texas Administrative Code §134.203 is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2010, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non-Facility Price or:

Code	Date of Service	MAR Calculation	Units	Allowable
62311	11/4/2010	Not eligible	1	\$0.00
62319	11/4/2010	$(68.19 / 36.8729) \times \$94.78$	1	\$175.28
77003	11/4/2010	$(68.19 / 36.8729) \times \$29.42$	1	\$54.41
62350	11/18/2010	$(68.19 / 36.8729) \times \$381.36$ less Multiple Procedure 50% reduction	1	\$352.63
62362	11/18/2010	$(68.19 / 36.8729) \times \$399.98$	1	\$739.69
62284	11/18/2010	$(68.19 / 36.8729) \times \$89.56$ less Multiple Procedure 50% reduction	1	\$82.82
95971	11/18/2010	$(68.19 / 36.8729) \times \$57.64$	1	\$106.60
77003	11/18/2010	$(68.19 / 36.8729) \times \$29.42$	1	\$54.41
			TOTAL	\$1,565.84

The total allowable for the disputed services is \$1,565.84. The carrier paid \$1,499.46 resulting in \$66.38 due the requestor.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$66.38.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$66.38, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### Authorized Signature

_____	_____	January 2, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**